

THE SCRIPPS RESEARCH INSTITUTE

Behavioral Health Benefits

JANUARY 1, 2004

Insured By

United HealthCare Insurance Company

Administered By



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Certification

INSURANCE BOOKLET
for Employees of
The Scripps Research Institute
(called the Employer)

insured by
UNITED HEALTHCARE INSURANCE COMPANY
Hartford, Connecticut
(called the Company)

This booklet becomes a Certificate of Insurance when:

- The Employee's name is shown below.
- The Employee has met the Eligibility requirements shown in the Certificate.

Name: _____
(Print name of Employee)

CERTIFICATE OF INSURANCE

United HealthCare Insurance Company has issued Group Policy No. GA-10730. It covers certain Employees of the Employer.

The policy provides behavioral health benefits.

This Certificate of Insurance describes the benefits and provisions of the policy. Additional benefits and provisions may apply based on the requirements of:

- The state where the policy is issued.
- The state where the Employee lives.

These state benefits and provisions are described in separate Amendments. See the Employer for details.

This is a Covered Person's Certificate of Insurance only while that person is insured under the policy. Dependents benefits apply only if the Employee is insured under the Employer's Plan for Dependent Benefits.

This Certificate describes the Plan in effect as of January 1, 2006.

This Certificate replaces any and all Certificates previously issued for Employees under the plan.

UNITED HEALTHCARE INSURANCE COMPANY



Allen J. Sorbo
President

The behavioral health benefits described in this Plan are administered by United Behavioral Health.

1-800-888-2998

C-CE2, C-SB1, C-EL1, C-RE1, C-MH2CA, C-CI1, C-CB3, C-RP1, C-EM1, C-TE1, C-GL1

Schedule of Benefits

Effective Date of this Plan: **January 1, 2004**

Behavioral Health Benefits

	Network*	Non-Network
Copayments		
Office Visit Copayment	\$20 Per Office Visit	Not Applicable
Percentage Payable after Deductibles/Copayments Satisfied		
	Network*	Non-Network
Mental Health/ Substance Abuse Inpatient	100%	50%
Mental Health/ Substance Abuse Outpatient	100% after Copayment	50%
Maximum Benefits		
Mental Health/ Substance Abuse Calendar Year Maximum Inpatient	30 Days	
Mental Health/ Substance Abuse Calendar Year Maximum Outpatient	40 Visits	
Substance Abuse Lifetime Maximum	Two Courses of Treatment	

*Pre-authorization required.

All benefits are paid in accordance with the Reasonable Charge. Refer to the Glossary for the definition of Reasonable Charge.

Non-Network services are subject to Utilization Review at the time a claim is submitted for payment in order to determine if the services are Covered Services.

Schedule of Benefits

Effective Date of this Plan: January 1, 2004

Behavioral Health Benefits - Graduate Students

	Network*	Non-Network
Percentage Payable		
	Network*	Non-Network
Mental Health/ Substance Abuse Inpatient and Outpatient	100%	50%
Maximum Benefits		
Mental Health/ Substance Abuse Calendar Year Maximum Inpatient	30 Days	
Mental Health/ Substance Abuse Calendar Year Maximum Outpatient	40 Visits	
Substance Abuse Lifetime Maximum	Two Courses of Treatment	

*Pre-authorization required.

All benefits are paid in accordance with the Reasonable Charge. Refer to the Glossary for the definition of Reasonable Charge.

Non-Network services are subject to Utilization Review at the time a claim is submitted for payment in order to determine if the services are Covered Services.

Eligibility

Eligible Employees

All full and part-time Employees of the Employer who are enrolled in a TSRI Medical Plan.

Employees must reside principally in the United States.

Eligible Dependents

Dependents are:

- A legal spouse of an eligible Employee.
- A Domestic Partner of an eligible Employee. A Domestic Partner is a person who is registered as your domestic partner with the California Secretary of State. If you live outside of California and do not have a partner registered with the California Secretary of State, "Domestic Partner: means a person who meets all of the following criteria:
 - a. Shares your permanent residence
 - b. Agrees with you to be jointly responsible for each other's basic living expenses. Basic living expenses are defined as the cost of basic food, shelter and any other living expenses. You need not contribute equally or jointly to the cost of these expenses as long as you agree that both are responsible for the cost.
 - c. Has not signed a domestic partner declaration with any other person.
 - d. Is not less than 18 years of age.
 - e. Is not legally permitted to marry you.
 - f. Is not currently legally married to any other person.
 - g. Is not a blood relative any closer than would prohibit legal marriage.

In addition to the above requirements, consent of either party to the Domestic Partner relationship must not have been obtained by force, duress or fraud.

- Any unmarried child from birth up to age 19 of an eligible Employee.
- An unmarried child under age 25 of an eligible Employee, if the child is a registered student in regular full-time attendance at school. The child must be mainly dependent on the Employee for care and support. The child cannot be employed on a regular full-time basis by one or more employers for a total of 30 or more hours per week.
- Any unmarried child, without regard to the child's age, who is not self-supporting due to:
 - Mental retardation
 - Physical handicap.

The Employee must give the Company proof, when requested, that the child meets these conditions. The company will not ask for proof more than once a year. Children who are not self-supporting must be mainly dependent on the Employee for care and support. These children must have become incapable of self-support either:

- Before reaching age 19.
- While covered as a Dependent under this Plan or any other group plan.

Child includes the following:

- A natural born child of the Employee.
- A stepchild who resides in the eligible Employee's home.
- A legally adopted child. (A child is considered legally adopted on the earlier of the date of placement or the date the legal adoption proceedings have been started.)

Dependents must reside principally in the United States.

Cost of Coverage

The coverage under this Plan is contributory. This means that Employees must make contributions toward the cost of coverage.

Enrollment Requirements

Enrollment Date

The date the person is enrolled under this Plan.

Employee Coverage

An Employee enrolls for Employee coverage by:

- completing an enrollment form, and
- giving the form to the Employer.

An Employee's enrollment is either timely or late.

An Employee is considered a timely enrollee if he or she enrolls during either the Initial Eligibility Period or a Special Enrollment Period.

An Employee is considered a late enrollee when he or she enrolls at any time other than during the Initial Eligibility Period or the Special Enrollment Period.

Dependent Coverage

No person can be covered both as an Employee and as a Dependent.

Initial Dependents are those family members who are eligible Dependents on the date the Employee first becomes eligible for Employee coverage.

Subsequent Dependents are any family members who become Eligible Dependents after the date the Employee first becomes eligible under this Plan. Subsequent Dependents may be added during a Special Enrollment Period.

A Dependent's enrollment is either timely or late.

A Dependent is considered a timely enrollee when he or she is enrolled for coverage during either the Initial Eligibility Period or a Special Enrollment Period.

A Dependent is considered a late enrollee when he or she is enrolled for coverage at any time other than the Initial Eligibility Period or the Special Enrollment Period.

Enrollment Periods

The Initial Eligibility Period is the 31-day period which begins on the date the person is first eligible under this Plan.

Special Enrollment Periods are available to certain persons who have lost other coverage and to certain dependents.

A Special Enrollment Period is available to a person who meets each of the following conditions:

- The Employee or Dependent was covered under a group health plan or had health insurance coverage or was covered under no-share-of-cost Medi-Cal coverage at the time coverage under this Plan was previously offered to the Employee or Dependent.
- The Employee stated in writing, at the time coverage was previously offered, that the other coverage was the reason for declining enrollment under this Plan. The Employer must have requested the statement at that time. The Employer must have provided the Employee with notice of this requirement (and its consequences) at that time. If the Company cannot produce the signed waiver form at the time the person wants to enroll, the provision does not apply.
- A court orders that coverage must be provided for a spouse or minor child under a covered Employee's Plan and the request for enrollment is made within 31 days after the issuance of the court order.
- The Employee's or Dependent's prior coverage was one of the following:
 - COBRA continuation which was exhausted.
 - Non-COBRA coverage which was terminated either as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer contributions towards such coverage were terminated.
- The Employee requests enrollment under this Plan not later than 31 days after the date of the end of the COBRA continuation, termination of coverage, or termination of Employer contribution.

A Special Enrollment Period is available to Subsequent Dependents. The Dependent Special Enrollment Period is the 31-day period which begins with the date the person becomes a Dependent.

If a Subsequent Dependent is enrolled, the Employee must enroll at the same time if not already covered. In addition, any of the Employee's other Dependents may be enrolled at the same time, if not already covered, subject to the same enrollment requirements.

If the Employee completes and submits an enrollment form for coverage after the first 31 days from the date of initial eligibility but the Employee does not satisfy one of the situations above or as stated in Continuous Creditable Coverage, the Employer will enroll the Employee as a late enrollee subject to a Preexisting Condition Exclusion of up to 12 months. A late enrollee may have to wait until the next annual enrollment period before coverage starts.

Effective Date of Employee Coverage

Employee coverage is effective on the date following the latest of:

- The Effective Date shown in the Schedule of Benefits;
- The date the Employee starts work if enrollment is completed within 31 days of the date of hire;
- The date the Employee enrolls for coverage as a special enrollee;
- The first day of the Plan year for a late enrollee who enrolled during the prior open enrollment period.

Effective Date of Dependent Coverage

Coverage for an Initial Dependent(s) is effective on the later of the following dates:

- The date the Employee becomes covered.
- The date the Employee enrolls the Dependents.

Coverage for a Subsequent Dependent is effective as follows:

- For Domestic Partners, the first administratively possible pay period following the date of attainment of Domestic Partner status, as per TSRI's policy guidelines.
- For a spouse, the first administratively possible pay period following the date of marriage.
- For a newborn child, the date of birth.
- For an adopted child, the date of adoption or placement for adoption.
- For any other child, the date the child becomes a Dependent.

Qualified Medical Child Support Order

If an Employee is required by a qualified medical child support order, as defined in the Omnibus Budget Reconciliation Act of 1993 (OBRA 93), to provide coverage for his/her children, these children can be enrolled as timely enrollees as required by OBRA 93.

If the Employee is not already enrolled, the Employee may also enroll as a timely enrollee at the same time.

Special Provision for Newborn Children

Plan Benefits are payable for a newborn child for 31 days after the child's birth, even if the Employee has not enrolled the child.

Behavioral Health Benefits

What This Plan Pays

Behavioral health benefits are payable for Covered Expenses incurred by a Covered Person for Behavioral Health Services received from Providers.

To receive the higher level of benefits, the Covered Person must call United Behavioral Health (UBH) before Covered Expenses are incurred. (See **Notification Requirements and Utilization Review.**)

Each Covered Person must satisfy certain Copayments before any payment is made for certain Behavioral Health Services. The behavioral health benefit will then pay the percentage of Covered Expenses shown in **Schedule of Benefits.**

A Covered Expense is incurred on the date that the Behavioral Health Service is given.

Covered Expenses are the actual cost to the Covered Person of the Reasonable Charge for Behavioral Health Services given. The Company, at its discretion, will calculate Covered Expenses following evaluation and validation of all Provider billings in accordance with the methodologies:

- In the most recent edition of the Current Procedural Terminology and/or DSM IV Code;
- As reported by generally recognized professionals or publications.

Behavioral Health Services are services and supplies which are:

- Covered Services, for MHSA Treatment.
- Given while the Covered Person is covered under this Plan.
- Given by one of the following providers:
 - Physician.
 - Psychologist.
 - Licensed Counselor.
 - Provider.
 - Hospital.
 - Treatment Center.
 - Social Worker.

Behavioral Health Services include but are not limited to the following:

- Assessment.
- Diagnosis.
- Treatment Planning.
- Medication Management.
- Individual, family and group psychotherapy.
- Psychological testing.
- Telemedicine. No face to face contact is required between a health care provider and a patient for services appropriately provided through telemedicine, subject to all terms and conditions of the Plan.

Services and supplies will not automatically be considered Covered Services because they were prescribed by a Provider.

Notification Requirements and Utilization Review

To receive the higher level of benefits under this Plan (called the Network level) and not incur the penalties shown below, the Covered Person must call United Behavioral Health (UBH) before inpatient Behavioral Health Services are given. **The toll-free number is 1-800-888-2998. UBH is ready to take the Covered Person's call 7 days a week, 24 hours a day.** This call starts the utilization review process. The Covered Person will be referred to a Network Provider who is experienced in addressing his/her specific issues.

Benefits under this Plan are reduced as follows if the Covered Person does not get a referral from UBH to a Network Provider before inpatient Behavioral Health Services are given:

- Benefits are payable at the Non-Network level, as shown in **Schedule of Benefits**.
- Benefits are subject to Utilization Review at the time a claim is submitted for payment in order to determine if the services incurred are Covered Services.

If the Covered Person is not satisfied with a Network Provider, he/she may call UBH and ask for a referral to another Network Provider. The Covered Person may do this more than once, but he/she will only be referred to one Network Provider at a time.

UBH performs a Utilization Review to determine whether the service or supply is a Covered Service. The Covered Person and his/her Provider decide which Behavioral Health Services are given, but this Plan only pays for Covered Services.

Emergency Care

Emergency Care does not require a referral from UBH to a UBH Network Provider.

When Emergency Care is required for MHA Treatment, the Covered Person (or his/her representative or his/her Provider) must call UBH within one day after the Emergency Care is given. If it is not reasonably possible to make this call within one calendar day, the call must be made as soon as reasonably possible.

When the Emergency Care has ended, the Covered Person must get a referral from UBH before any additional services will be covered at the Network level. If the Covered Person does not get a referral as required, benefits for any additional services are payable at the Non-Network level.

The Plan will pay for all Covered Services rendered to Covered Person prior to stabilization of the Covered Person's Emergency Care, or during periods of destabilization when the Covered Person needs immediate Emergency Care. The Company will pay for Emergency Care regardless of the Provider's contract status with UBH. Covered Persons are encouraged to use appropriately the "911" emergency response system, where established, when an emergency medical condition exists that requires an emergency response.

Copayments

Before behavioral health benefits are payable, each Covered Person must satisfy certain Copayments.

A Copayment is the amount of Covered Expenses the Covered Person must pay to a Network Provider at the time services are given. Behavioral Health Services which require a Copayment are not subject to a Deductible.

The amount of each Copayment is shown in **Schedule of Benefits**. A Covered Expense can only be used to satisfy one Copayment.

Office Visit Copayment

The Office Visit Copayment applies to services given by a Network Provider. It applies to all services and supplies given in connection with each office visit.

Maximum Benefit

The Maximum Benefit payable for each Covered Person is shown in **Schedule of Benefits**. This maximum applies to each Covered Person's lifetime.

The Maximum Benefit includes any amount paid under the Employer's group health plan in effect on the day before the effective date of this Plan.

Extended Benefits

Extended Benefits are payable for a Totally Disabled Covered Person for up to 3 months. Extended Benefits are only payable for Behavioral Health Services given during the 3-month period after the person's coverage ends.

The person must be continuously Totally Disabled due to the same cause from the date coverage ends until the date Behavioral Health Services are given.

Extended Benefits are only payable for Behavioral Health Services given for the injury or sickness causing Total Disability.

What's Not Covered - Exclusions

The following exclusions apply regardless of whether the services, supplies, or treatment described in this section are recommended or prescribed by the Covered Person's Provider and/or the only available treatment options for the Covered Person's condition.

This Plan does not cover services, supplies or treatment relating to, arising out of, or given in connection with the following:

- Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of Mental Health Disorders (DSM).
- Prescription drugs or over the counter drugs and treatments. (Refer to your medical plan to determine whether prescription drugs are a covered benefit.)
- Services or supplies for MHSA Treatment that, in the reasonable judgment of UBH are any of the following:
 - not consistent with the symptoms and signs of diagnosis and treatment of the behavioral disorder, psychological injury or substance abuse;
 - not consistent with prevailing national standards of clinical practice for the treatment of such conditions;
 - not consistent with prevailing professional research demonstrating that the service or supplies will have a measurable and beneficial health outcome;

- typically do not result in outcomes demonstrably better than other available treatment alternative that are less intensive or more cost effective; or
- not consistent with UBH's Level of Care Guidelines or best practices as modified from time to time.

UBH may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information.

- Treatment or services, except for the initial diagnoses, for a primary diagnoses of Mental Retardation (317,318,319), Learning, Motor Skills, and Communication Disorders (315), Pervasive Developmental Disorder (299), Conduct Disorder (312), Dementia (290, 294), Sexual, Paraphilia, and Gender Identity Disorders (302), and Personality Disorders (301), as well as other mental illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to modification or management according to prevailing national standards of clinical practice, as reasonably determined by UBH.
- Unproven, Investigational or Experimental Services. Services, supplies, or treatments that are considered unproven, investigational, or experimental because they do not meet generally accepted standards of medical practice in the United States. The fact that a service, treatment, or device is the only available treatment for a particular condition will not result in it being a Covered Service if the service, treatment, or device is considered to be unproven, investigational, or experimental.
- Custodial Care except for the acute stabilization of the Covered Person and returning the Covered Person back to his or her baseline levels of individual functioning. Care is determined to be custodial when:
 - it provides a protected, controlled environment for the primary purpose of protective detention and/or providing services necessary to assure the Covered Person's competent functioning in activities of daily living; or
 - it is not expected that the care provided or psychiatric treatment alone will reduce the disorder, injury or impairment to the extent necessary for the Covered Person to function outside a structured environment. This applies to Covered Persons for whom there is little expectation of improvement in spite of any and all treatment attempts.

Covered Persons whose repeated and volitional non-compliance with treatment recommendations result in a situation in which there can be no reasonable expectation of a successful outcome.

- Neuropsychological testing when used for the diagnosis of attention deficit disorder.
- Examinations or treatment, unless it otherwise qualifies as Behavioral Health Services, when:
 - required solely for purposes of career, education, sports or camp, travel, employment, insurance or adoption;
 - ordered by a court except as required by law;
 - conducted for purposes of medical research; or
 - required to obtain or maintain a license of any type.
 - Herbal medicine, holistic or homeopathic care, including herbal drugs, or other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.
- Nutritional Counseling, except as prescribed for the treatment of primary eating disorders as part of a comprehensive multimodal treatment plan.
- Weight reduction or control programs (unless there is a diagnosis of morbid obesity and the program is under medical supervision), special foods, food supplements, liquid diets, diet plans or any related products or supplies.
- Services or treatment rendered by unlicensed Providers, including pastoral counselors (except as required by law), or which are outside the scope of the Providers' licensure.

- Personal convenience or comfort items including, but not limited to, such items as TVs, telephones, computers, beauty/barber service, exercise equipment, air purifiers or air conditioners.
- Light boxes and other equipment including durable medical equipment, whether associated with a behavioral or non-behavioral condition.
- Private duty nursing services while confined in a facility.
- Surgical procedures including but not limited to sex transformation operations.
- Smoking cessation related services and supplies.
- Travel or transportation expenses unless UBH has requested and arranged for Covered Person to be transferred by ambulance from one facility to another.
- Services performed by a Provider who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the Provider may perform on himself or herself.
- Services performed by a Provider with the same legal residence as the Covered Person.
- Behavioral Health Services for which the Covered Person has no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan.
- Charges in excess of any specified Plan limitations.
- Any charges for missed appointments.
- Any charges for record processing except as required by law.
- Services Provided Under Another Plan. Services or treatment for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. This includes but is not limited to coverage required by workers' compensation, no-fault auto, or similar legislation. If coverage under workers' compensation or a similar law is optional for Covered Person because Covered Person could elect it or could have it elected for him or her, benefits will not be paid if coverage would have been available under the workers' compensation or similar law had that coverage been elected.
- Behavioral Health Services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country when Covered Person is legally entitled to other coverage.
- Treatment or services received prior to Covered Person being eligible for coverage under the Plan or after the date the Covered Person's coverage under the Plan ends.

Network Provider Charges Not Covered

A Network Provider has contracted to participate in the Network and provide services at a negotiated rate. Under this contract a Network Provider may not charge for certain expenses, except as stated below. A Network Provider cannot charge for:

- Services or supplies which are not Covered Services;
- Fees in excess of the negotiated rate.

A Covered Person may agree with the Network Provider to pay any charges for services and supplies which are not Covered Services. In this case, the Network Provider may make charges to the Covered Person. The Covered Person will be asked to sign a patient financial responsibility form agreeing to pay for the services that are found to not be Covered Services. However, these charges are not Covered Expenses under this Plan and are not payable by the Company.

Claims Information

How to File a Claim

A claim form does not need to be filed when a Network Provider is used.

The following steps should be completed when submitting bills for payment:

- Get a claim form from the Employer, the Plan Administrator or United Behavioral Health.
- Complete the Employee portion of the form.
- Have the Provider complete the Provider portion of the form.
- Send the form and bills to the address shown on the form.

Make sure the bills and the form include the following information:

- The Employee's name and social security number.
- The Employer's name and contract number (10730).
- The patient's name.
- The diagnosis.
- The date the services or supplies were incurred.
- The specific services or supplies provided.

If the covered Employee asks for a claim form but does not receive it within 15 days, the covered Employee can file a claim without it by sending the bills with a letter, including all of the information listed above.

When Claims Must be Filed

The covered Employee must give the Company written proof of loss within 15 months after the date the expenses are incurred.

The Company will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested.

No benefits are payable for claims submitted after the 15-month period, unless it can be shown that:

- It was not reasonably possible to submit the claim during the 15-month period.
- Written proof of loss was given to the Company as soon as was reasonably possible.

How and When Claims Are Paid

UBH will make a benefit determination as set forth below. Benefits will be paid to the covered Employee as soon as United Behavioral Health receives satisfactory proof of loss, except in the following cases:

- If the covered Employee has financial responsibility under a court order for a Dependent's medical care, United Behavioral Health will make payments directly to the Provider of care.
- If United Behavioral Health pays benefits directly to Network Providers.
- If the covered Employee requests in writing that payments be made directly to a Provider. A covered Employee does this when completing the claim form.

These payments will satisfy the Company's obligation to the extent of the payment.

United Behavioral Health will send an Explanation of Benefits (EOB) to the covered Employee. The EOB will explain how United Behavioral Health considered each of the charges submitted for payment. If any claims are denied or denied in part, the covered Employee will receive a written explanation.

Any benefits continued for Dependents after a covered Employee's death will be paid to one of the following:

- The surviving spouse.
- A Dependent child who is not a minor, if there is no surviving spouse.
- A Provider of care who makes charges to the covered Employee's Dependents for Behavioral Health Services.
- The legal guardian of the covered Employee's Dependent.

SHOULD A DISPUTE CONCERNING A CLAIM ARISE, CONTACT UBH FIRST. IF THE DISPUTE IS NOT RESOLVED, CONTACT THE CALIFORNIA DEPARTMENT OF INSURANCE.

CALL UBH AT THE PHONE NUMBER SHOWN ON YOUR EXPLANATION OF BENEFITS.

CALL THE CALIFORNIA DEPARTMENT OF INSURANCE AT 1-800-927-HELP (1-800-927-4357) IF THE COVERED PERSON RESIDES IN THE STATE OF CALIFORNIA.

(213) 897-8921 IF THE COVERED PERSON RESIDES OUTSIDE OF THE STATE OF CALIFORNIA.

A COVERED PERSON MAY WRITE THE CALIFORNIA DEPARTMENT OF INSURANCE AT:

**CALIFORNIA DEPARTMENT OF INSURANCE
CLAIMS SERVICES BUREAU, 11TH FLOOR
300 SOUTH SPRING STREET
LOS ANGELES, CA 90013**

Benefit Determinations

Pre-service Claims

Pre-service claims are those claims that require notification or approval prior to receiving Behavioral Health Services. If the Covered Person's claim was a pre-service claim, and was submitted properly with all needed information, the Covered Person will receive written notice of the claim decision from UBH within 15 days of receipt of the claim. If the Covered Person filed a pre-service claim improperly, UBH will notify the Covered Person of the improper filing and how to correct it within five days after the pre-service claim was received. If additional information is needed to process the pre-service claim, UBH will notify the Covered Person of the information needed within 15 days after the claim was received, and may request a one-time extension not longer than 15 days and pend the Covered Person's claim until all information is received. Once notified of the extension, the Covered Person then has 45 days to provide this information. If all of the needed information is received within the 45-day time frame, UBH will notify the Covered Person of the determination within 15 days after the information is received. If the Covered Person does not provide the needed information within the 45-day period, the claim will be denied. A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

Concurrent Care Claims

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and the request to extend the treatment is an urgent claim as defined below, the Covered Person's request will be decided upon within 24 hours, provided the request is made at least 24 hours prior to the end of the approved treatment. UBH will make a determination on the request for the extended treatment within 24 hours from receipt of the request. If the request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent claim and decided according to the timeframes described below.

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and the Covered Person's request to extend treatment is a non-urgent circumstance, the request will be considered a new claim and decided according to pre-service or post-service timeframes, whichever applies.

Post-service Claims

Post-service claims are those claims that are filed for payment of benefits after Behavioral Health Services have been received. If the Covered Person's post-service claim is denied, he or she will receive a written notice from UBH within 30 days of receipt of the claim, as long as all needed information was provided with the claim. UBH will notify the Covered Person within this 30-day period if additional information is needed to process the claim, and may request a one-time extension not longer than 15 days and pend the claim until all information is received.

Once notified of the extension, the Covered Person then has 45 days to provide this information. If all of the needed information is received within the 45-day time frame, and the claim is denied, UBH will notify the Covered Person of the denial within 15 days after the information is received. If the Covered Person does not provide the needed information within the 45-day period, his or her claim will be denied.

A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

Urgent Claims that Require Immediate Attention

Urgent claims are those Emergency Care claims that require notification or a benefit determination prior to receiving MHSA Treatment. In these situations:

- The Covered Person will receive notice of the benefit determination in writing or electronically within 72 hours after UBH receives all necessary information, taking into account the seriousness of the Covered Person's condition.
- Notice of denial may be oral with a written or electronic confirmation to follow within three days.

If the Covered Person files an urgent claim improperly, UBH will notify the Covered Person of the improper filing and how to correct it within 24 hours after the urgent claim was received. If additional information is needed to process the claim, UBH will notify the Covered Person of the information needed within 24 hours after the claim was received. The Covered Person then has 48 hours to provide the requested information.

The Covered Person will be notified of a benefit determination no later than 48 hours after:

- UBH's receipt of the requested information; or
- The end of the 48-hour period which the Covered Person was given to provide the additional information, if the information is not received within that time.

A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

Questions or Concerns about Benefit Determinations

If the Covered Person has a question or concern about a benefit determination, he or she may informally contact UBH's customer service department before requesting a formal appeal. If the Covered Person is not satisfied with a benefit determination as described above, he or she may appeal it as described below, without first informally contacting a customer service representative. If the Covered Person first informally contacted UBH's customer service department and later wishes to request a formal appeal in writing, the Covered Person should again contact customer service and request an appeal. If the Covered Person requests a formal appeal, a customer service representative will provide the Covered Person with the appropriate address.

If the Covered Person is appealing an urgent claim denial, please refer to the *Urgent Claim Appeals that Require Immediate Action* section below and contact UBH's Appeals Unit immediately.

How to Appeal a Claim Decision

If the Covered Person disagrees with a claim determination after following the above steps, he or she can contact UBH in writing to formally request an appeal. If the appeal relates to a claim for payment, the request should include:

- The patient's name and the identification number.
- The date(s) of service(s).
- The Provider's name.
- The reason the Covered Person believes the claim should be paid.
- Any documentation or other written information to support the request for claim payment.

The Covered Person's first level appeal request must be submitted to UBH within 180 days after he or she receives a claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If the appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field, who was not involved in the prior determination. UBH may consult with, or seek the participation of, medical experts as part of the appeal resolution process. The Covered Person consents to this referral and the sharing of pertinent medical claim information. Upon request and free of charge, the Covered Person has the right to reasonable access to and copies of all documents, records, and other information relevant to his or her claim for benefits.

Appeals Determinations

First Level Pre-service and Post-service Claim Appeals

The Covered Person will be provided written or electronic notification of the decision on the appeal as follows:

For appeals of **pre-service claims** and **post-service claims** as identified above, the Covered Person will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim.

Urgent Claim Appeals that Require Immediate Action

An appeal may require immediate action if a delay in treatment could significantly increase the risk to the Covered Person's health, or the ability to regain maximum function. In these urgent situations:

The appeal does not need to be submitted in writing. The Covered Person or his or her Physician should call UBH as soon as possible.

UBH will provide the Covered Person with a written or electronic determination within 72 hours following receipt of the request for review of the determination, taking into account the seriousness of the Covered Person's condition.

Independent Medical Review

If the Covered Person still disagrees with the results of the internal appeal determination, Covered Person may request an Independent Medical Review if the adverse benefit determination involves clinical issues. In order to request an Independent Medical Review, Covered Person must:

Apply for an Independent Medical Review within six months of the qualifying periods or events described below. The Director of the Department of Corporations or Department of Insurance may extend the application deadline beyond six months if the circumstances of a case warrant the extension. The Covered Person shall pay no application or processing fees of any kind.

All of the following conditions must be met in order for the Covered Person to apply for an Independent Medical Review.

- The Covered Person's Provider has recommended a health care service as medically necessary or the Covered Person has received Emergency Care that a Provider determined was medically necessary or, in the absence of either of the foregoing, the Covered Person has been seen by a Network Provider for the diagnosis or treatment of the medical condition for which the individual seeks independent review. UBH shall expedite access to a Network Provider upon request. The Network Provider does not have to recommend the disputed health care service as a condition for the individual to be eligible for an independent review. The individual's Provider may be a Non-Network Provider. However, the Plan shall have no liability for payment of services provided by a Non-Network Provider.
- The disputed health care service has been denied, modified, or delayed based in whole or in part on a decision that the health care service is not medically necessary.

- The Covered Person has filed an appeal with UBH and the disputed decision is upheld or the appeal remains unresolved after 30 days. (A Covered Person shall not be required to participate in the UBH's appeal process for more than 30 days. If the appeal requires an expedited review, the Covered Person shall not be required to remain in the appeal process more than three days.)

For procedures associated with urgent claims, see ***Urgent Claim Appeals That Require Immediate Action*** below.

Please note that UBH's decision is based only on whether or not benefits are available under the policy for the proposed treatment or procedure.

Legal Actions

The Covered Person may not sue on a claim before the Covered Person has exhausted the Company's internal appeals process. The Covered Person may not sue after three years from the time proof of loss is required, unless the law in the area where the Covered Person lives allows for a longer period of time.

Incontestability of Coverage

This Plan cannot be declared invalid after it has been in force for two years. It can be declared invalid due to nonpayment of premium.

No statement used by any person to get coverage can be used to declare coverage invalid if the person has been covered under this Plan for two years. In order to use a statement to deny coverage before the end of two years, it must have been signed by the person. A copy of the signed statement must be given to the person.

Information and Records

At times we may need additional information from you. The Covered Person must agree to furnish United Behavioral Health with all information and proofs that we may reasonably require regarding any matters pertaining to the Policy. If the Covered Person does not provide this information when we request it we may delay or deny payment of Benefits.

By accepting the Behavioral Health Services under the Policy, you authorize and direct any person or institution that has provided services to you to furnish us with all information or copies of records relating to the services provided to you. We have the right to request this information at any reasonable time. This applies to all Covered Person, including Dependents whether or not they have signed the Employee enrollment form. We agree that such information and records will be considered confidential.

We have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Policy, for appropriate medical review or quality assessment, or as we are required to do by law or regulation. During and after the term of the Policy, we and our related entities may use and transfer the information gathered under the Policy in a de-identified format for commercial purposes, including research and analytic purposes.

For complete listings of your medical records or billing statements we recommend that you contact your Provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from us, we also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, we will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Our designees have the same rights to this information as we have.

A statement describing UBH's policies and procedures for preserving the confidentiality of medical records is available and will be furnished to you upon request.

Coordination of Benefits

Coordination of benefits applies when a covered Employee or a covered Dependent have health coverage under this Plan and one or more Other Plans.

One of the plans involved will pay the benefits first: that plan is Primary. Other Plans will pay benefits next: those plans are Secondary. The rules shown in this provision determine which plan is Primary and which plan is Secondary.

Whenever there is more than one plan, the total amount of benefits paid in a Calendar Year under all plans cannot be more than the Allowable Expenses charged for that Calendar Year.

Definitions

"Other Plans" are any of the following types of plans which provide health benefits or services for medical care or treatment:

- Group policies or plans, whether insured or self-insured. This does not include school accident-type coverage.
- Group coverage through HMOs and other prepayment, group practice and individual practice plans.
- Group-type plans obtained and maintained only because of membership in or connection with a particular organization or group.
- Government or tax supported programs. This does not include Medicare or Medicaid.

"Primary Plan": A plan that is Primary will pay benefits first. Benefits under that plan will not be reduced due to benefits payable under Other Plans.

"Secondary Plan": Benefits under a plan that is Secondary may be reduced due to benefits payable under Other Plans that are Primary.

"Allowable Expenses" means the necessary, reasonable and customary expense for health care when the expense is covered in whole or in part under at least one of the plans.

The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an Allowable Expense unless the patient's stay in a private hospital room is medically necessary either in terms of generally accepted medical practice, or as defined in the plan.

When a plan provides benefits in the form of services, instead of a cash payment, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

How Coordination Works

When this Plan is Primary, it pays its benefits as if the Secondary Plan or Plans did not exist.

When this Plan is a Secondary Plan, its benefits are reduced so that the total benefits paid or provided by all plans during a Calendar Year are not more than total Allowable Expenses. The amount by which this Plan's benefits have been reduced shall be used by this Plan to pay Allowable Expenses not otherwise paid, which were incurred during the Calendar Year by the person for whom the claim is made. As each claim is submitted, this Plan determines its obligation to pay for Allowable Expenses based on all claims which were submitted up to that point in time during the Calendar Year.

The benefits of this Plan will only be reduced when the sum of the benefits that would be payable for the Allowable Expenses under the Other Plans, in the absence of provisions with a purpose like that of this **Coordination of Benefits** provision, whether or not claim is made, exceeds those Allowable Expenses in a Calendar Year.

When the benefits of this Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan.

Which Plan Pays First

When two or more plans provide benefits for the same Covered Person, the benefit payment will follow the following rules in this order:

- A plan with no coordination provision will pay its benefits before a plan that has a coordination provision.
- The benefits of the plan which covers the person other than as a dependent are determined before those of the plan which covers the person as a dependent.
- The benefits of the plan covering the person as a dependent are determined before those of the plan covering that person as other than a dependent, if the person is also a Medicare beneficiary and both of the following are true:
 - Medicare is secondary to the plan covering the person as a dependent.
 - Medicare is primary to the plan covering the person as other than a dependent (example, a retired employee).
- When this Plan and another plan cover the same child as a dependent of parents who are not separated or divorced, the benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year. This is called the "Birthday Rule." The year of birth is ignored.

If both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of the plan which covered the other parent for a shorter period of time.

If the other plan does not have a birthday rule, but instead has a rule based on the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

- If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
 - First, the plan of the parent with custody for the child.
 - Second, the plan of the spouse of the parent with the custody of the child.
 - Finally, the plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent shall be the Secondary Plan. This rule does not apply with respect to any claim for which any benefits are actually paid or provided before the entity has that actual knowledge.

- If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules that apply to dependents of parents who are not separated or divorced.
- The benefits of a plan which covers a person as an employee who is neither laid off nor retired are determined before those of a plan which covers that person as a laid off or retired employee. The same rule applies if a person is a dependent of a person covered as a retiree or an employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

If none of the above rules determines the order of benefits, the benefits of the plan which covered the Covered Person for the longer period are determined before those of the plan which covered that person for the shorter period.

Facility of Payment

It is possible for benefits to be paid first under the wrong plan. The Company may pay the plan or organization or person for the amount of benefits that the Company determines it should have paid. That amount will be treated as if it was paid under this Plan. The Company will not have to pay that amount again.

Right of Recovery

The Company may pay benefits that should be paid by another plan or organization or person. The Company may recover the amount paid from the other plan or organization or person.

The Company may pay benefits that are in excess of what it should have paid. The Company has the right to recover the excess payment.

Recovery Provisions

Refund of Overpayments

If the Company pays benefits for expenses incurred on account of a Covered Person, that Covered Person or any other person or organization that was paid must make a refund to the Company if:

- All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- All or some of the payment made by the Company exceeded the benefits under this Plan.

The refund equals the amount the Company paid in excess of the amount it should have paid under this Plan.

If the refund is due from another person or organization, the Covered Person agrees to help the Company get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, the Company may reduce the amount of any future benefits that are payable under this Plan. The Company may also reduce future benefits under any other group benefits plan administered by the Company for the Employer. The reductions will equal the amount of the required refund. The Company may have other rights in addition to the right to reduce future benefits.

Reimbursement of Benefits Paid

If the Company pays benefits for expenses incurred on account of a Covered Person, the Employee or any other person or organization that was paid must make a refund to the Company if all or some of the expenses were recovered from or paid by a source other than this Plan as a result of claims against a third party for negligence, wrongful acts or omissions. The refund equals the amount of the recovery or payment, up to the amount the Company paid.

If the refund is due from another person or organization, the Covered Person agrees to help the Company get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, the Company may reduce the amount of any future benefits that are payable under this Plan. The Company may also reduce future benefits under any other group benefits plan administered by the Company for the Employer. The reductions will equal the amount of the required refund. The Company may have other rights in addition to the right to reduce future benefits.

Effect of Medicare and Government Plans

Medicare

When a Covered Person becomes eligible for Medicare, this Plan pays its benefits in accordance with the Medicare Secondary Payer requirements of federal law. If the Employer is subject to the Medicare Secondary Payer requirements, this Plan will pay primary.

When This Plan Pays Primary to Medicare

This Plan pays primary to Medicare for Covered Persons who are Medicare eligible if:

- Eligibility for Medicare is due to age 65 and the employee has "current employment status" with the employer as defined by federal law and determined by the employer.
- Eligibility for Medicare is due to disability and the employee has "current employment status" with the employer as defined by federal law and determined by the employer.
- Eligibility for Medicare is due to end stage renal disease (ESRD) under the conditions and for the time periods specified by federal law.

When Medicare Pays Primary to this Plan

Medicare pays primary to this Plan for Covered Persons who are Medicare eligible if:

- The employee is a Retired Employee.
- Eligibility is due to disability and the Employee does NOT have "current employment status" with the employer as defined by federal law and determined by the employer.
- Eligibility for Medicare is due to end stage renal disease (ESRD), but only after the conditions and/or time periods specified in federal law cause Medicare to become primary.

See **How this Plan Pays When Medicare is Primary**.

Important! - Medicare Enrollment Requirements

When this Plan pays benefits first, without regard to Medicare, and the Covered Person wants Medicare to pay after this Plan, the Covered Person must enroll for Medicare Parts A and B. If the Covered Person does not enroll for Medicare when he or she is first eligible, the Covered Person must enroll during the special enrollment period which applies to that person when the person stops being eligible under this Plan.

When Medicare pays benefits first, benefits available under Medicare are deducted from the amounts payable under this Plan, whether or not the person has enrolled for Medicare. If Medicare pays first, the Covered Person should enroll for both Parts A and B of Medicare when that Covered Person is first eligible; otherwise, the expenses may not be covered by the Plan or Medicare.

How This Plan Pays When Medicare Is Primary

If Medicare pays benefits first, this Plan pays benefits as described below. This method of payment only applies to Medicare eligibles. It does not apply to any Covered Person unless that Covered Person becomes eligible under Medicare.

If the Provider has agreed to limit charges for services and supplies to the charges allowed by Medicare (participating physicians), this Plan determines the amount of Covered Expenses based on the amount of charges allowed by Medicare.

If the Provider has not agreed to limit charges for services and supplies to the charges allowed by Medicare (non-participating physicians), this Plan determines the amount of Covered Expenses based on the lesser of the following:

- The Reasonable Charges.
- The amount of the Limiting Charge as defined by Medicare.

This Plan determines the amount payable without regard to Medicare benefits. Then this Plan subtracts the amount payable under Medicare for the same expenses from Plan benefits. This Plan pays only the difference between Plan benefits and Medicare benefits.

The amount payable under Medicare which is subtracted from this Plan's benefits is determined as the amount that **would have been payable to a Medicare eligible covered under Medicare even if:**

- The person is not enrolled for Medicare Parts A and B. Benefits are determined as if the person were covered under Medicare Parts A and B.
- The expenses are paid under another employer's group health plan which is primary to Medicare. Benefits are determined as if benefits under that other employer's plan did not exist.
- The person is enrolled in a Health Maintenance Organization (HMO) or Competitive Medical Plan (CMP) to receive Medicare benefits, and receives unauthorized services (out-of-plan services not covered by the HMO/CMP). Benefits are determined as if the services were authorized and covered by the HMO/CMP.

Government Plans (other than Medicare and Medicaid)

If the Covered Person is also covered under a Government Plan, this Plan does not cover any services or supplies to the extent that those services or supplies, or benefits for them, are available to that Covered Person under the Government Plan.

This provision does not apply to any Government Plan which by law requires this Plan to pay primary.

A Government Plan is any plan, program, or coverage — other than Medicare or Medicaid — which is established under the laws or regulations of any government, or in which any government participates other than as an employer.

Termination of Coverage

Employee Coverage

Employee coverage ends on the earliest of the following:

- The last day of the month in which your employment terminates.
- The first day of the next administratively possible pay period after the date you are no longer eligible for coverage under the plan.
- The first day of the next administratively possible pay period after the date Human Resources receives, in writing, your intent to stop medical coverage for yourself due to a qualified status change by completing a Benefits Coverage change form.
- The date the plan terminates.

The end of the period for which you paid contributions, if you do not make the next required contribution when due.

Disability

The Employer has the right to continue a person's employment and coverage under this Plan during a period in which the person is away from work due to disability. The period of continuation is determined by the Employer based on the Employer's general practice for an Employee in the person's job class.

Coverage ends on the date the Employer notifies the Company that the person's employment has stopped and coverage is to be ended.

Leave of Absence or Temporary Layoff

The Employer has the right to continue the person's employment and coverage under this Plan during a period in which the person is away from work due to an approved leave of absence or temporary layoff. The period of continuation is determined by the Employer based on the Employer's general practice for an Employee in the person's job class.

Coverage will end on the date the Employer notifies the Company that the person is no longer covered.

Dependent Coverage

Coverage for all of an Employee's Dependents ends on the earlier of the following:

- The day the Employee's coverage ends.
- The last day of a period for which contributions for the cost of Dependent coverage have been made, if the contributions for the next period are not made when due.

Coverage for an individual Dependent ends on the earlier of:

- The day the Dependent becomes covered as an Employee under this Plan.
- The day the Dependent stops being an eligible Dependent.

Termination Notice

If the group policy is terminated, the Company will notify the Employer in writing. The Employer will promptly send Covered Persons a copy of the termination notice by mail. The Employer will promptly provide the Company with proof of this mailing.

If the group policy terminates, a Covered Person may continue his/her coverage in accordance with U.S. Public Law 99-272 (COBRA).

Continuation of Coverage

Continuation of Coverage for Incapacitated Children

A mentally or physically incapacitated child's coverage will not end due to age. It will continue as long as Dependents coverage under this Plan continues and the child continues to meet the following conditions:

- The child is incapacitated.
- The child is not capable of self-support.
- The child depends mainly on the Employee for support.

The Employee must give the Company proof that the child meets these conditions when requested. The Company will not ask for proof more than once a year.

Continuation of Coverage for Former Employees Age 60 and Older

An Employer subject to COBRA shall offer to eligible former Employees and their spouses the opportunity to continue the Plan's benefits after COBRA continuation ends, subject to terms and conditions of the Plan. The former Employee must elect in writing to continue his/her own and his/her spouse's coverage within 30 calendar days prior to the date coverage under COBRA is scheduled to end. The former Employee must pay the Company any required premium for the coverage under this provision.

To be eligible, the former Employee must:

- Be 60 years of age or older on the date employment ends.
- Have worked for the employer for at least five years prior to the date employment ends.
- Be entitled to and elects to continue benefits under COBRA (U.S. Public Law 99-272).

Coverage will stop on the earlier of the following:

- The date the Employee or his/her spouse reaches age 65.
- The date the former Employer ceases to maintain any group health plan.
- The date the former Employee or his/her spouse is covered under another group health plan not maintained by the Employer, regardless of whether that coverage is less valuable.
- The date the former Employee or his/her spouse becomes eligible under Medicare.
- Five years from the date the former Employee's employment ended, with respect to the Employee's spouse.

Continuation of Coverage for Former Spouses of Employees and Former Employees

If a Former Spouse of an Employee or former Employee was covered as a qualified beneficiary under COBRA, the Former Spouse may further continue benefits of this Plan beyond the date coverage under COBRA ends, subject to terms and conditions of the Plan.

A "Former Spouse" is one of the following:

- An individual divorced from an Employee or former Employee.
- An individual who was married to an Employee or former Employee at the time of the death of the Employee or former Employee.

The Former Spouse must elect in writing to continue his/her coverage within 30 calendar days prior to the date coverage under COBRA is scheduled to end. The Former Spouse must pay the Company any required premium for the coverage under this provision.

The continuation coverage for the Former Spouse will end automatically on the earliest of the following dates:

- The date the individual reaches 65 years of age.
- The date the individual is covered under any group health plan not maintained by the Employer, regardless of whether that coverage is less valuable.
- The date the individual becomes entitled to Medicare.
- Thirty-six months from the date on which continuation coverage under COBRA was scheduled to end for the Former spouse.
- The date on which the Employer or former Employer terminates its group contract with the Company and ceases to provide coverage for any active employees through that Company, in which case the Company will notify the former spouse of the right to Conversion Coverage.

Reinstatement of Coverage

Participants who have resigned or have been terminated from TSRI for a period of ninety (90) days or less and are reemployed shall have all coverage in effect prior to termination reinstated.

Glossary

(These definitions apply when the following terms are used.)

Behavioral Health Services

- Services and supplies which are:
 - Covered Services for MHSA Treatment.
 - Given while the Covered Person is covered under the plan.
 - Given by one of the following providers:
 - Physician.
 - Psychologist.
 - Licensed Counselor.
 - Provider.
 - Hospital.
 - Treatment Center.
 - Social Worker

- Behavioral Health Services include but are not limited to the following:
 - Assessment.
 - Diagnosis.
 - Treatment Planning.
 - Medication Management.
 - Individual, family and group psychotherapy.
 - Psychological testing.

Calendar Year

A period of one year beginning with a January 1.

Course of Treatment

A period of MHSATreatment during which Behavioral Health Services are received by a Covered Person on a continuous basis until there is a period of interruption (that is, the Covered Person is treatment-free) for more than:

- 30 days with respect to treatment for substance abuse
- 6 months with respect to treatment for mental illness

Covered Expenses

The actual cost to the Covered Person of the Reasonable Charge for Behavioral Health Services given.

Covered Person

The Employee and the Employee's wife or husband and/or Dependent children who are covered under this Plan.

Covered Services

Those services and supplies provided for the purpose of preventing, diagnosing or treating a behavioral disorder, psychological injury or substance abuse addiction and which are described in the section titled "What This Plan Pays," and not excluded under the section titled "What's Not Covered - Exclusions."

Emergency Care

Immediate MHSA Treatment when the lack of the treatment could reasonably be expected to result in the patient harming himself or herself and/or other persons.

Screening, examination and evaluation by a Physician, or other Provider to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a psychiatric emergency exists, and the care and treatment necessary to relieve or eliminate the psychiatric emergency, within the capability of the facility.

Employee

A person on the payroll of the Employer and regularly employed by the Employer on a full-time basis of not less than 20 hours per week.

Hospital

An institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets one of the following three tests:

- It is accredited as a hospital by the Joint Commission on Accreditation of Healthcare Organizations.
- It is approved by Medicare as a hospital.
- It meets all of the following tests:
 - It maintains on the premises diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of duly qualified Physicians.
 - It continuously provides on the premises 24-hour-a-day nursing service by or under the supervision of registered graduate nurses.
 - It is operated continuously with organized facilities for operative surgery on the premises.
 - It is licensed by the California State Department of Health Services, or it operates under a waiver of licensure granted by the California State Department of Mental Health.

Licensed Counselor

A person who specializes in MHSA Treatment and is licensed as a Licensed Professional Counselor (LPC) or Licensed Clinical Social Worker (LCSW) by the appropriate authority.

Medicare

The Health Insurance For The Aged and Disabled program under Title XVIII of the Social Security Act.

MHSA Treatment

MHSA Treatment is mental health and/or substance abuse treatment for the following:

- Any sickness which is identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), including a psychological and/or physiological dependence or addiction to alcohol or psychoactive drugs or medications, regardless of any underlying physical or organic cause, and
- Any sickness where the treatment is primarily the use of psychotherapy or other psychotherapeutic methods.

All inpatient services, including room and board, given by a mental health facility or area of a Hospital which provides mental health or substance abuse treatment for a sickness identified in the DSM, are considered MHSA Treatment, except in the case of multiple diagnoses.

If there are multiple diagnoses, only the treatment for the sickness which is identified in the DSM is considered MHSA Treatment.

Detoxification services given prior to and independent of a course of psychotherapy or substance abuse treatment is not considered MHSA Treatment.

Prescription Drugs are not considered MHSA Treatment.

Network Provider

A Provider which participates in the United Behavioral Health network.

Non-Network Provider

A Provider which does not participate in the United Behavioral Health network.

Physician

A legally qualified:

- Doctor of Medicine (M.D.).
- Doctor of Osteopathy (D.O.).

Plan

The group policy or policies issued by the Company which provide the benefits described in this Certificate of Insurance.

Provider

A person who is qualified and duly licensed or certified by the state in which he or she is located to furnish MESA Treatment.

Psychologist

A person who specializes in clinical psychology and fulfills one of these requirements:

- A person licensed or certified as a psychologist.
- A Member or Fellow of the American Psychological Association, if there is no government licensure or certification required.

Reasonable Charge

As to charges for services rendered by or on behalf of a Network Physician, an amount not to exceed the amount determined by the Company in accordance with the applicable fee schedule.

As to all other charges, an amount measured and determined by the Company by comparing the actual charge for the service or supply with the prevailing charges made for it. The Company determines the prevailing charge. It takes into account all pertinent factors including:

- The complexity of the service.
- The range of services provided.
- The prevailing charge level in the geographic area where the Provider is located and other geographic areas having similar medical cost experience.

Telemedicine

The practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. It is the above-covered medical services that an individual receives from a health care provider without person-to-person contact with the provider. It is not consultation by telephone or facsimile machine between health care providers or between patient and health care provider.

Total Disability or Totally Disabled

- An Employee's inability to perform, with reasonable continuity, all of the substantial and material duties of his or her regular employment or occupation.
- A Dependent's inability to perform the normal activities of a person of like age and sex.

Treatment Center

A facility which provides a program of effective MHPA Treatment and meets all of the following requirements:

- It is established and operated in accordance with any applicable state law.
- It provides a program of treatment approved by a Physician and the Company.
- It has or maintains a written, specific and detailed regimen requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services:
 - Room and board (if this Plan provides inpatient benefits at a Treatment Center).
 - Evaluation and diagnosis.
 - Counseling.
 - Referral and orientation to specialized community resources.

A Treatment Center which qualifies as a Hospital is covered as a Hospital and not as a Treatment Center.

Utilization Review

A review and determination as to the Clinical Necessity of services and supplies.

End of Certificate

Continuation of Coverage (COBRA)

This optional continuation only applies to Employees and their Dependents if it has been made available by the Employer. The Employer is required to offer this continuation in certain cases as a result of Public Law 99-272 (COBRA). This provision is intended to comply with the law and any pertinent regulations, and its interpretation is governed by them. See the Employer to find out if and how this continuation applies to Employees and their Dependents.

In no event will the Company be obligated to provide continuation to a Covered Person if the Employer or its designated plan administrator fails to perform its responsibilities under federal law. These responsibilities include but are not limited to notifying the Covered Person in a timely manner of the right to elect continuation and notifying the Company in a timely manner of the Covered Person's election of continuation. The Company is not the Employer's designated Plan Administrator and does not assume any responsibilities of a Plan Administrator pursuant to federal law.

If coverage under this Plan would have stopped due to a Qualifying Event, a Qualified Beneficiary may elect to continue coverage subject to the provisions below.

The Qualified Beneficiary may continue only the coverage in force immediately before the Qualifying Event.

The coverage being continued will be the same as the coverage provided to similarly situated individuals to whom a Qualifying Event has not occurred.

Coverage will continue until the earliest of the following dates:

- 18 months from the date the Qualified Beneficiary's coverage would have stopped due to a Qualifying Event based on employment stopping or work hours being reduced.
- If a Qualified Beneficiary is determined to be disabled under the Social Security Act at any time during the first 60 days of continued coverage due to the employee's employment stopping or work hours being reduced, that Qualified Beneficiary may elect an additional 11 months of coverage under this Plan, subject to the following conditions:
 - The Qualified Beneficiary must provide the Employer with the Social Security Administration's determination of disability within 60 days of the time the determination is made and within the initial 18-month continuation period.
 - The Qualified Beneficiary must agree to pay any increase in the required payment necessary to continue the coverage for the additional 11 months.
 - If the Qualified Beneficiary entitled to the additional 11 months of coverage has nondisabled family members who are entitled to continuation coverage, those nondisabled family members are also entitled to the additional 11 months of continuation coverage.
- 36 months from the date the coverage would have stopped due to the Qualifying Event other than those described above.
- The date this Plan stops being in force.
- The date the Qualified Beneficiary fails to make the required payment for the coverage.
- The date the Qualified Beneficiary becomes entitled to benefits under Medicare.
- The date the Qualified Beneficiary, after electing this continuation, becomes covered under any other group health plan. (This does not apply if the other group health plan excludes or limits coverage for a Qualified Beneficiary's preexisting condition.)

If the Qualified Beneficiary is already covered under any other group health plan and elects continuation of coverage under this Plan, the Qualified Beneficiary must stop coverage under that other group health plan. If the Qualified Beneficiary does not stop coverage under that other plan, coverage under this continuation will stop.

If after the first Qualifying Event another Qualifying Event occurs, coverage can be continued for an additional period, for a total of 36 months from the date of the first Qualifying Event.

Coverage will stop for the same reasons as coverage would have stopped for the first Qualifying Event.

Election Period

A Qualified Beneficiary has at least 60 days to elect to continue coverage. The election period ends on the later of:

- 60 days after the date coverage would have stopped due to the Qualifying Event.
- 60 days after the date the person receives notice of the right to continue coverage.

Unless otherwise specified, an Employee or spouse's election to continue coverage will be considered an election on behalf of all other Qualified Beneficiaries who would also lose coverage because of the same Qualifying Event.

Required Payments

A Qualified Beneficiary has 45 days from the date of election to make the first required payment for the coverage. The first payment will include any required payment for the continued coverage before the date of the election.

Notification Requirements

A Qualified Beneficiary must notify the Employer within 60 days when any of the following Qualifying Events happen:

- The Qualified Beneficiary's marriage is dissolved.
- The Qualified Beneficiary becomes legally separated from his or her spouse.
- A child stops being an eligible Dependent.

The Employer will send the appropriate Election Form to the Qualified Beneficiary within 14 days after receiving this notice.

Claims

File a claim by completing a medical claim form and attaching your bills to the form. "COBRA" should be written on the claim form and on each of the bills.

Special Terms that Apply to this Continuation Provision

Qualifying Event

A Qualifying Event is any of the following which results in loss of coverage for a Qualified Beneficiary:

- The Employee's employment ends (except in the case of gross misconduct).
- The Employee's work hours are reduced.
- The Employee becomes entitled to benefits under Medicare.
- The Employee's death.
- The Employee's marriage is dissolved.
- The Employee becomes legally separated from his/her spouse.
- The Employee's Dependent child stops being an eligible Dependent.

A bankruptcy is a Qualifying Event for certain Retired Employees and their Dependents under certain conditions. If there is a bankruptcy, Retired Employees should contact the Employer or the Company for more information.

Qualified Beneficiary

Any of the following persons who are not entitled to Medicare on the day before a Qualifying Event:

- The Employee.
- An Employee's spouse.
- An Employee's former spouse (or legally separated spouse).
- A Dependent child, including a child born to or placed for adoption with the Employee during a period of continued coverage.

Continuation of Coverage After COBRA Is Exhausted (CalCOBRA)

If a Qualified Beneficiary, as defined above, is entitled to less than 36 months of continuation coverage under COBRA, and he/she has exhausted the continuation coverage under COBRA, he/she may continue coverage under CalCOBRA for up to 36 months from the date of his/her Qualifying Event, as defined above. The combination of COBRA and CalCOBRA continuation coverage may not exceed 36 months from the date of the Qualifying Event.

Continuation of Coverage During Family and Medical Leave (FMLA)

The Family and Medical Leave Act of 1993 (FMLA) requires Employers to provide up to a total of 12 weeks of unpaid, job-protected leave during any 12-month period to eligible Employees for certain family and medical reasons. This provision is intended to comply with the law and any pertinent regulations, and its interpretation is governed by them. See the Employer to find out details about how this continuation applies to you.

Reasons for Taking Leave

FMLA leave must be granted for any of the following reasons:

- Care of a child after birth.
- Care of a child after placement of that child with the Employee for adoption or foster care.
- Care of the Employee's spouse, child or parent (but not a parent-in-law) who has a serious health condition.
- A serious health condition that makes the Employee unable to work.

Employee Eligibility

To be eligible for FMLA benefits, all of the following must be true:

- The Employee must work for a covered Employer.
- The Employee must have worked for the Employer for at least 12 months.
- The Employee must have worked at least 1,250 hours over the previous 12 months.
- The Employee must work at a location where at least 50 employees are employed by the Employer within 75 miles.

Advance Notice and Medical Certification

The Employee must provide advance notice and medical certification. Taking of leave may be denied if requirements are not met.

- The employee ordinarily must provide 30 days advance notice when the leave is "foreseeable."
- If the need for the leave is unforeseen, notice must be given as soon as practicable.
 - An Employer may require medical certification to support a request for leave because of a serious health condition, and may require a second or third opinion (at the Employer's expense) and a fitness for duty report to return to work.

Continuation of Coverage, Job Benefits and Protection

For the duration of a FMLA leave, the Employer must maintain the Employee's coverage. The Employee may continue the Plan benefits for himself or herself and his or her Dependents on the same terms as if the Employee had continued to work. The Employee must pay the same contributions toward the cost of the coverage that he or she made while working.

If the Employee fails to make the payments on a timely basis, the Employer, after giving you written notice, can end the coverage during the leave if payment is more than 30 days late.

- Upon return from a FMLA leave, most Employees must be restored to their original or equivalent positions with equivalent pay, benefits and other employment terms.
- The use of a FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an Employee's leave.

See the Employer for details about continuing group coverage other than the Plan benefits.

Intermittent Leave

Under some circumstances, an Employee may take a FMLA leave intermittently which means taking a leave in blocks of time, or by reducing his or her normal weekly or daily work schedule.

- Where a FMLA leave is for birth or placement for adoption or foster care, use of intermittent leave is subject to the Employer's approval.
- A FMLA leave may be taken intermittently whenever it is medically necessary to care for a seriously ill family member, or because the Employee is seriously ill and unable to work.

Substitution of Paid Leave

Subject to certain conditions, Employees or Employers may choose to use accrued **paid** leave (such as sick or vacation leave) to cover some or all of the FMLA leave. The Employer is responsible for designating if paid leave used by the Employee counts as a FMLA leave, based on information provided by the Employee. In no case can an Employee's paid leave be credited as a FMLA leave **after** the leave has been completed.

Spouses Who Work for the Same Employer

Spouses employed by the same Employer are jointly entitled to a **combined** total of 12 work weeks of family leave for the birth of a child or placement of a child for adoption or foster care, and to care for such child or to care for a parent who has a serious health condition.

Reenrollment after a FMLA Leave

If any or all of an Employee's coverages end while the Employee is on a FMLA leave, the Employee can reenroll for coverage when he or she returns to work from the FMLA leave.

The Employee and any Dependents will be considered timely enrollees if the Employee reenrolls within 31 days from the date he or she returns to work.

Summary Plan Description

for

The Scripps Research Institute

January 1, 2004

This Booklet is a Covered Person's Summary Plan Description for purposes of the Employee Retirement Income Security Act of 1974 (ERISA). It describes the highlights of a Covered Person's rights and obligations under the employee welfare benefit plan established by the Plan Sponsor, provided that the Covered Person is a participant of the Plan. All of the details of this Plan are not provided. The operation of this Plan is governed by the Plan Documents. For more information about the Plan Documents, refer to the section, "A Covered Person's Rights Under ERISA."

The Plan Sponsor reserves the right to change or discontinue this Plan at any time. This Summary Plan Description does not create a contract of employment.

Name of Plan:

The Scripps Research Institute Welfare Benefit Plan

Name and Address of Employer who is the Plan Sponsor:

The Scripps Research Institute
10550 North Torrey Pines Road
La Jolla, California 92037

Employer Identification Number of Plan Sponsor (EIN):

33-0435954

Agent for Legal Process:

The Plan Sponsor named above.

Plan Number (PN):

501

Plan Type:

The Plan described in this Summary Plan Description is a "Welfare Benefit Plan" for purposes of ERISA.

Plan Years:

The financial records of this Plan are kept on a Plan Year basis. The Plan Year ends on each January 1.

Plan Administrator:

The Plan Sponsor named above.

Telephone Number of Plan Administrator:

(619) 784-8734

Type of Administration:

This Plan is administered on behalf of the Plan Administrator by United Behavioral Health, San Francisco, California, pursuant to the terms of the group insurance policy issued by United HealthCare Insurance Company, Hartford, Connecticut.

Source of Contributions and Funding:

This Plan is funded by the payment of premium required by the insurance policy.

The Employee's contribution toward the cost of this Plan is at a rate determined by the Employer.

Plan Details:

This Plan's provisions relating to eligibility to participate and termination of eligibility as well as a description of the benefits provided by this Plan are described in detail in the Covered Person's insurance certificate which directly precedes this ERISA information.

Plan Amendment and Termination:

The Plan Sponsor reserves the right to modify, suspend or terminate this Plan at any time. The Employer does not promise the continuation of any benefits nor does it promise any specific level of benefits at or during retirement. Any benefits, rights or obligations of participants and beneficiaries under this Plan following termination are described in detail in the Covered Person's insurance certificate which directly precedes this ERISA information.

The Plan Sponsor adopts all provisions of the insurance policy issued by the Company as amended from time to time, as part of this Plan when it arranges for and maintains the insurance provided for in the policy.

How to Appeal a Claim:

A Covered Person will be notified in writing by the Company if a claim or any part of a claim is denied. The notice will include the specific reason or reasons for the denial and the reference to the pertinent Plan provisions on which the denial was based. The notice will also give the telephone number a Covered Person can call if they need further information and a description of any additional material or information necessary to make a claim.

If a Covered Person is not satisfied with the explanation of why the claim was denied, the person may request to have the claim reviewed. The request must be in writing to the Company and must be made within 60 days after the date the Covered Person receives the notice denying the claim.

If a Covered Person does not hear from the Company within 90 days after the Company receives the claim, the Covered Person may consider the claim denied and request to have the claim reviewed.

A decision will be made within 60 days after the receipt of a request for review or the date all information required from the Covered Person is given. If, because of extenuating circumstances, the Company is unable to complete the review process within 60 days, the Company will notify the Covered Person of the delay within the 60-day period and will provide a final written response to the request for review within 120 days of the date the Company received the written request for review.

The Company will serve as the final review committee under this Plan to determine for all parties all questions relating to the payment of claims for benefits under this Plan and shall notify the Covered Person in writing about the decision on a review. The Company has the discretion to construe and interpret the terms of this Plan and the authority and responsibility to make factual determinations.

The provisions of this Plan require a Covered Person to appeal any claim denial as described above before seeking other legal means.

A Covered Person's Rights under ERISA:

As a participant in this Plan, a Covered Person is entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants are entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all Plan documents including insurance contracts and copies of all documents filed by the Plan with the U.S. Department of Labor and the Internal Revenue Service, such as detailed annual reports and Plan descriptions.
- Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Administrator may make a reasonable charge for the copies.
- Receive a summary of this Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan.

The people who operate this Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of Covered Persons and other Plan participants and beneficiaries.

No one, including the Employer or any other person, may fire a Covered Person or otherwise discriminate against a Covered Person in any way to prevent that person from obtaining a benefit or exercising their rights under ERISA.

If a claim for a benefit is denied in whole or in part, a Covered Person must receive a written explanation of the reason for the denial. The Covered Person has the right to have the Plan review and reconsider the claim.

Under ERISA, there are steps a Covered Person can take to enforce the above rights. For instance, if a Covered Person requests materials from the Plan and does not receive them within 30 days, the Covered Person may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay the Covered Person up to \$110 a day until the person receives the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If a Covered Person has a claim for benefits which is denied or ignored, in whole or in part, the Covered Person may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse this Plan's money, or if a Covered Person is discriminated against for asserting his or her rights, the Covered Person may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Covered Person is successful, the court may order the person who was sued to pay these costs and fees. If the Covered Person loses, the court may order the Covered Person to pay these costs and fees (for example, if it finds the person's claim is frivolous).

If a Covered Person has any questions about this Plan, the person should contact the Plan Administrator.

If a Covered Person has any questions about this statement or about his or her rights under ERISA, that person should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.